PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	KS FUR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		297104	B. WING		03/31/2009
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
AT HOM	E HEALTH SERVICE			E. Russell Road Vegas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION S) GROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLÉTION PROPRIATE DATE
G 000	INITIAL COMMEN	rs	G 000	5-27-09 accep	table plan
	a result of the Medi under 42 CFR Part	Deficiencies was generated as care re-certification survey 484 - Home Health Services, agency from March 25, 2009 2009.		5-27-09 accept of correction i minor correction = Dod/clinical CEA	inth a few ins via telephon Director
·	was 56. Fifteen clinical reco- four closed records Five home visits we The findings and co- by the Health Divisi prohibiting any crim- actions or other cla available to any pa- state, or local laws.	ere conducted, enclusions of any investigation ion shall not be construed as sinal or civil investigations, ims for relief that may be try under applicable federal,		CEA	estburger
G 143	identified. 484.14(g) COORDI SERVICES All personnel furnis to ensure that their effectively and sup- the plan of care. This STANDARD is Based on clinical re- review, the facility is furnishing services effectively coordina	hing services maintain liaison efforts are coordinated bort the objectives outlined in service and document ailed to ensure all persons maintained liaison in order to the and support the objectives of care for 10 of 15 patients 12, 14, 15).	G 143	A. The Agency will immediately disciplines in order to impro- effectively support the plan of communicate with each other needed (i.e. change in plan of physician is communicated patient's status occurs. Al communication in the visit note area/box on the clinical no completes a written Case Co weeks and as necessary. This Director/QA staff. In addition, discharge is communicated to the final visit as evidenced by visit note. Patients 1,2,5,8,12,14 and 15 I discharged. Patients 3, 7, & 9 patients will benefit from the improvided by this plan of correct	ove coordination of care to of care. Disciplines verbally every two (2) weeks and as care). Coordination with the when any changes in the I disciplines document this es in the coordination of care tes. Also, each discipline inference form every two (2) is submitted to the Clinical coordination of the patient's the appropriate disciplines on y documentation on the final have already been and all current & future inproved coordination of care
ASORATOR	OUA TOUR	DERKUPPLIER RESENTATIVES SIGN	ATURE C	Unical Director	5/8/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requised to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID. 3VPH11

Facety ID NV\$3658HHA

If continue REGERVED

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PRINTED 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICANE	G MEDICAD SCITTISES	1				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED	
		297104	B WING_			03/31/2009	
	ROVIDER OR SUPPLIER		27	21 E. Rus	DRESS. CITY, STATE, ZIP CODE sell Road NV 89120		
AT HOME	HEALTH SERVICE						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	PREFIX TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
G 143	Continued From pa	ge 1	G 143	В.	through QA monitoring of concurrent documentation of		
	Findings include:				liaison/coordination between all services, as well as the physicia all written case conference form	. In addition, tracking of	
	Patient #1				the Clinical Director.	s will be completed by	
	The start of care fo Diagnoses included heart failure and no mellitus.		C1.	The Agency has scheduled a m May 8, 2009 for all disciplines or coordination/liaison and docume coordination. The in-service wa Clinical Director (See Agenda service instructed disciplines on communication/coordination of	n care entation of the s presented by the ' Attachment A). This in-		
	A skilled nurse (SN times. A physical t 14 times.			every two (2) weeks and as nee physician, and documentation of be evident in the clinical notes, case conference forms was included to present the same mandatory	ded, as well as with the ithis communication will Instruction on written uded. The Agency plans in-service during the		
	On 7/6/08, the SN of non-compliant - do has unsteady gait."			week of May 11-15, 2009, with a disciplines documented.			
	In the lower left har		C2.	The QA staff will be instructed or of this communication.	n monitoring documentation		
	Visit Notes (SNVN) indicate care coord physician, PT, occurrence of the coord physician, PT, occurrence of the coordinate of the coordinat	i, was an area for the SN to lination had occurred with the upational therapist (OT), ST) and/or social services (SS).		C3.	A telephone directory of discipline disciplines and the disciplines with care, and as the plan of care characteristic disciplines involved. The disciplines involved. The disciplines phone number of the physician's phone number of	Il be informed at the start of inges, of the names of lisciplines will be directed to	
	left hand corner lac	Patient #1, the area in the lower cked any documentation coordinated care with PT inpliance of patient regarding		D.	Monitoring the corrective action of tracking of written case conferent Director. In addition the QA staff documentation of verbal communisciplines, and with physicians of intervene as necessary.	ce forms by the Clinical f will monitor the nication between	
	On 8/1/08, the PT just above the sign Patient #1.		E.	The Clinical Director will be responsible for monitoric compliance of this corrective action. The QA staff wand report to the clinical director in monitoring the documentation. In addition, the Clinical Director/QA will report monthly to the PI committee in regards to Agency's compliance with this corrective action.			
	to document coord OT and/or other. I documentation indi	wo lines above " see O/C", there was an area of document coordination with the physician, SN, o'T and/or other. The clinical record lacked ocumentation indicating PT had notified SN egarding Patient #1's discharge.			Date of completion: June 19, 20	09	

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Event ID.3VPH11

Facility ID NVS3688HHA

If continuation sheet Page 2 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1' '	LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		297104	B. WI	IG	·	03/3	1/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE			39	EET ADDRESS, CITY, STATE, ZIP CODE 60 EAST PATRICK, #202 AS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 143	Diagnoses included anticoagulants, dee not specified and ch disease (COPD). Patient #2 was seen patient was seen by On 12/11/08, PT disclinical record lacker PT advised SN of the Patient #3 The start of care for Diagnoses included (Parkinson's disease After the start of care Patient #3 on 3/24/0 on 3/25/09. The clinical record In OT communicated coordinate care for Patient #5 The start of care for Diagnoses included (CHF), hypertension bladder incontinence On 12/16/08, PT sa only. The clinical resord in the clinical resord.	Patient #2 was 11/11/08. I long term current use of ap vein thrombosis (DVT) site pronic pulmonary obstructive in by SN nine times. The PT twice. Scharged Patient #2. The ed documentation indicating the discharge. Patient #3 was 3/20/09. I paralysis agitans (e) and difficulty walking. The by SN, PT evaluated (19). OT evaluated the patient walking acked documentation PT and with each other and the SN to Patient #3. Patient #5 was 12/13/08. I congestive heart failure in, difficulty walking and see. I we Patient #5 for an evaluation ecord lacked documentation ecord lacked documentation.	G.	143			
		notified that PT would not be					†

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Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 3 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPLE	
			B. WNG			
		297104	D. WING _		03/3	1/2009
	PROVIDER OR SUPPLIER E HEALTH SERVICE		3:	REET ADDRESS, CITY, STATE, ZIP CODE 960 East Patrick, #202 AS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 143	six times. The final discharge summary indicating SN was in Patient #7 The start of care for Diagnoses included heart failure, insuling muscle weakness at PT saw Patient #7 on 3/11/09. The clidocumentation individed heart of care for Diagnoses included a history of falls. PT saw Patient #8 1/22/09. The clinical documentation individed physician and SN of COT saw Patient #8 patient on 12/31/08 documentation individed discharge.	for additional visits. herapist (OT) saw Patient #5 I OT revisit note and the OT y lacked documentation notified of the OT discharge. If Patient #7 was 12/18/08, d hypertension, congestive n-dependent diabetes mellitus, and difficulty walking. If or seven visits and discharged inical record lacked cating the physician and SN of the discharge. If Patient #8 was 11/12/08, d arthritis, difficulty walking and If or 18 visits and discharged on al record lacked icating OT had notified the	G 143	DEFICIENCY		
	1	or Patient #9 was 2/21/09. d pressure ulcer, coronary				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 4 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		297104	B. WI	IG		03/3	1/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE			39	EET ADDRESS, CITY, STATE, ZIP CODE 960 EAST PATRICK, #202 AS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 143	3/6/09 indicating Pa (date unknown). The documentation indic OT were notified of Patient #12 The start of care for Diagnoses included difficulty walking and On 2/19/09, PT discrevisit note lacked of nurse on the case of discharge from PT. Patient #14 The start of care for Diagnoses included hypertension and compunicated with care. Patient #15 The start of care for Diagnoses included communicated with care.	a missed visit report (MVR) on attent #9 went into the hospital he clinical record lacked cating physician, SN, PT and the patient's status. The Patient #12 was 1/19/09. If hypertension, chronic pain, and bipolar disease. The Patient #12. The PT documentation indicating the was notified of the patient's The Patient #14 was 2/25/09. If multiple sclerosis, oronary disease. The Patient #14 lacked cating SN and PT reach other to coordinate The Patient #15 was 2/24/09. If multiple sclerosis, chronic ary disease, hypertension and diabetes mellitus.	G	1443			
		documented on a revisit note,					

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Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 5 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

107 Car (V 3 Tay)	to i oit incolorite	d HILDIOMO OLITAIOLO	1		··	Omo mo.	0300-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUILDING		NSTRUCTION	(X3) DATE SI COMPLE	
		297104	B WNG			03/3	1/2009
NAME OF P	ROVIDER OR SUPPLIER		1			· · · · · · · · · · · · · · · · · · ·	
AT HOME	E HEALTH SERVICE		2721	E. Russ	DRESS, CITY, STATE, ZIP CODE sell Road sV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
G 143	Continued From pa	ge 5	G 143				
	secondary to fear o	f seizures."					
	indicating SN was r fear of exercise brir	* *					
	Note: The patient v medication. The plant as a diagnosis.						
	stated on page 3 of paperwork will inclu- discipline; include n	r, "Management of er 7:20, effective on 6/22/06, 4,"#4. The final visit de: A. Visit note for that otification of other team d e.g. CHHA (certified home					
G 144	484.14(g) COORDI SERVICES	NATION OF PATIENT	G 144	A.	The Agency will ensure that case evidenced by completed docume	entation in the	clinical records
	The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Disciplines will be required other disciplines on visit no needed for any charges in Care. A written case confe two (2) weeks, and as neer occur. Patients 1,2,6,12,13,14 & 1		other disciplines on visit notes evereded for any changes in the pacare. A written case conference two (2) weeks, and as needed populations 1,2,6,12,13,14 & 15 have current and future patients will be	the patient's condition or Plan of rence form will be completed every led per change in the Plan of Care. 5 have all been discharged. All			
		s not met as evidenced by: cord review, the facility failed		8.	All patients' clinical records will be compliance with Case Conference will report to the Clinical Director	e Notes by the	
	to ensure effective is coordination of patie case conferences for 6, 7, 8, 12, 13, 14, 1		C.	The Agency has scheduled a madisciplines on case conferenceed conferences. This in-service was Director on May 8, 2009 (See Ag Agency plans to repeat this in-set 11-15, 2009 with mandatory attendocumented. QA staff has been	ocumentation s presented by jenda - Attach ervice during the ndance by <u>all</u> instructed on	of these / the Clinical ment A). The ne week of May disciplines	
	Findings include:				compliance with case conference		İ
	Patients #1, 2, 6, 12 SN and PT.	2, 13, 14 and 15 were seen by					

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Event ID 3VPH11

Facility ID NVS3688HHA

If continuation sheet Page | 6 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	CS FUR WEDICARE	& MEDICARD SERVICES				····	1	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Ι' '	ULTIPLE LDING	CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
		297104	8 MIN	ıç			03/31/2009	
NAME OF P	ROVIDER OR SUPPLIER					DRESS. CITY, STATE, ZIP CODE sell Road		
AT HOME	E HEALTH SERVICE					W 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHOT DSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
G 144	Continued From pa	ge 6 n by SN, PT and occupational	G ·	144	D.	 Monitoring the corrective action will be accon by tracking of written case conference forms Clinical Director and QA staff. In addition, the 		
	therapy (OT).					will monitor the documentation communication/coordination to intervene as necessary.	n of verbal	
;	Patient #7 was seen by SN, PT and certified nursing assistant (CNA). Patient #8 was seen by SN, CNA, PT and OT. The clinical records for Patients #1, 2, 5, 6, 7, 8,				E.	The Clinical Director will be re compliance of this corrective		
·						assist and report to the Clinica the corrective action. In addit Director/QA staff will report m	ion, the Clinical	
	12, 13, 14 and 15 k	12, 13, 14 and 15 lacked documentation indicating case conferences occurred.				committee in regards to the A this corrective action.	gency's compliance with	
	•	D AM, the Director of Nurses			F.	Date of Completion: June 19	, 2009	
		Ference occurred "every						
G 145	484.14(g) COORD SERVICES	COORDINATION OF PATIENT		145	Α.	The Agency will ensure that do the 60-day summary of care in documentation of progress or	ncludes	
		report for each patient is sent ysician at least every 60 days.				made by the patients.		
					B.	Compliance with this correction QA monitoring of the documer all patients.	n will be verified by ntation provided for	
	Based on clinical reto provide the phys	s not met as evidenced by: ecord review, the agency failed ician with a written summary is for 6 of 15 patients (#1, 2, 5,			C.	The Agency held a mandatory disciplines on proper documer day summary on May 8, 2009 Attachment A). This in-service the Clinical Director during the 15, 2009, with mandatory atte	ntation on the 60- (See Agenda will be repeated by week of May 11-	
	Findings include:					disciplines documented. QA sinstructed on monitoring comp	staff will be liance with the 60-	
	8 contained a docu	ical records for patients #1, 2, 5, 6, 7 and ned a document titled "60-day Summary."				day summary, and report any Clinical Director for immediate		
	diagnoses, the ser	each patient included the vices provided by the agency atients continued to require.			D.	Monitoring the corrective action accomplished by review of 60- the QA staff that will report to Director and intervene as necessary	day summaries by the Clinical	
	and 8 lacked docu	aries for patients #1, 2, 5, 6, 7 mentation indicating the nereof) made by these patients.						

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Event ID 3VPH11

Facaty ID: NVS3688HHA

If continuation sheet Page 7 of 33



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	8 MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPE A BUILDING		STRUCTION	(X3) DATE SE COMPLE	
		297104	B. WING			03/3	1/2009
	ROYIDER OR SUPPLIER E HEALTH SERVICE		2721	E. Rus	DRESS, CITY, STATE, ZIP CODE ISEII Road NV 89120		:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPI DEFICIENCY)	JULO BE	(X5) CCAPLETION DATE
G 158	Care follows a writt and periodically revosteopathy, or podi. This STANDARD is Based on clinical reto ensure care folloestablished by the (#1, 2, 5, 6, 7, 8, 11). Findings include: Patient #1 The start of care for Diagnoses include heart failure and no mellitus. Patient #1's plan of to be weighed ween ones lacked docur was ever weighed. Patient #2 The start of care for Diagnoses include anticoagulants, deen ot specified and or disease (COPD). The start of care or receive Lovenox 10	s not met as evidenced by cord review, the agency failed wed a written plan of care physician for 9 of 15 patients (14, 15). The Patient #1 was 6/20/08. If hypertension, congestive on-insulin dependent diabetes for a indicated the patient was kly. All skilled nursing visit mentation indicating the patient of a present thrombosis (DVT) site thronic pulmonary obstructive ders called for Patient #2 to 00 milligrams subcutaneously the days and Coumadin 7.5	G 158	A. C.	The Agency will ensure the orders are followed as will care. Orders obtained will regards to wound care, Prequencies of visits by difrequencies of wound care. Any missed visits will be ophysician and an order for frequency will be obtained will be completed for all p CNA services. The Agendiscipline frequencies are care. Patients 1,2,5,8,8,1 discharged. Orders for all 11 will be obtained as we and future patients who will be corrective action. The Agency will obtain procare and will coordinate we ensure all orders are specified per plan of care. Physicial obtained consistently for a patients' POC. The Agency scheduled a service for all disciplines of Care on May 8, 2009 (See Attachment A). This in-serepeated by the Clinical Diveck of May 11-15, 2009 all disciplines documented instructed to monitor visits to ensure all services con orders/Plans of Care. The will continue to QA all phyorders/POCs.	itten per the ill be specific T/INR testin sciplines, e or Foley communicator any changed. CNA care atients receively will ensure followed per a 15 haysician order with the physician orders will any changes mandatory in mMD order e Agenda envice will be birector during with attended. QA staff is and clinical ply with physicianal physician orders will be birector will be birector will be birector during with attended. QA staff is and clinical physician physician orders will be birector will be birector will be birector during with attended of the clinical physician physician physician orders will be birector will be birector during with attended of the clinical physician physici	Plan of c in g, are, etc. ed to the e in plans ving re that all replan of been ients 7 & urrent from licians to ried out I be s in the s/Plan of lighther ance by has been I notes visician

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Event ID: 3VPH11

Facility ID INVS3688HHA

If continuation sheet Page 8 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		297104	B. WING		03/31/2009
NAME OF P	ROVIDER OR SUPPLIER		272	REET ADDRESS. CITY, STATE, ZIP CO 21 E. Russell Road	DE
AT HOM	HEALTH SERVICE		Las	s Vegas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
	The clinical record indicating the SN c specific orders for Note: Patient #2 w facility six days afte 11. The target ran DVT is between two	rders indicated Patient #2 was ab draw) per MD order." lacked documented evidence alled the physician to ask for a frequency of lab draws. ras admitted to an acute care er start of care with an INR of ge of INR for a patient with	G 158	D. Monitoring the corrective accomplished by QA of the Clinical Director. The QA Clinical Directory by mone to ensure compliance. The assist the Clinical Directory documentation to show the frequencies are being fol are communicated to the patient care is delivered established by the physic will report any problems/ the Clinical Director for in	ne plan of care by the staff will assist the itoring clinical notes the QA staff will also or by monitoring nat orders and visit lowed, missed visits physician and per plan of care sian. The QA staff assued immediately to mediate resolution of the plan of care the care items.
	Patient #5 The start of care for Patient #5 was 12/13/08. Diagnoses included congestive heart failure, hypertension, difficulty walking and bladder incontinence. Patient #5's initial plan of care indicated the patient was to be weighed weekly. The skilled nurses visit notes lacked documentation indicating the patient was ever weighed. On 1/22/09, the licensed practical nurse (LPN) documented Patient #5 had a pressure sore in the coccyx area. On 1/22/09, the LPN wrote the following orders: "Cleanse coccyx wound with NS (normal saline) pat dry apply Hydrogel cover with gauze secure with tape q (every) day." The order did not indicate skilled nursing (SN) was to teach a caregiver how to perform the wound care. The order did not indicate the SN frequency was to increase to daily.			monitoring and ensuring of patients' written plan of castaff will assist the Clinical monitoring visit frequencial physician of missed visits report to the Clinical Direction frequencies or problem the plan of care. The Clinical discipline will prepare a refor the changes in the plasigned by the MD. The Clinical plan of care are not plan of care. The Clinical that a CNA care plan is confollowed for each patient addition, the Clinical Direction monthly to the PI control to the Agency's compliant action. F. Date of completion: June	are/MD orders. QA I Director by es and notifying the . The QA staff will eter of any changes s with compliance to aical Director/licensed evised interim order in of care to be linical Director will t being followed per Director will monitor completed and as indicated. In eter/QA staff will committee in regards ce with this corrective

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Event ID:3VPH11

Facility ID: NVS3668HHA

If continuation sheet Page 9 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
	į.	297104	B. WINC	<u> </u>	03/3	31/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP C 3960 EAST PATRICK, #202 LAS VEGAS, NV 89120	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 158	The LPN saw Paties the patient on 2/7/0 The recertification of "Cleanse wound wi bacitracin ointment dressing." The order frequency with which changed. The order change the dressing Patient #6 The start of care for Diagnoses included retention and non immellitus. The plan of care for 12/5/08 - 2/2/09 increased by SN two times then, one time a weak for eight wea	ent #5 on 1/29/09. The RN saw 99 for recertification. orders written by the RN read, ith saline, pat dry, apply and Duoderm/Flexicol ers did not include the ch the dressing was to be ers did not include who was to 19. or Patient #6 was 10/6/08. Ith the dressing was to be ers did not include who was to 19. or Patient #6 was 10/6/08. Ith the certification period dicated Patient #6 was to be nes a week for two weeks and eek for seven weeks.	G 19	58		

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Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 10 of 33



DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297104	B. WI	NG		03/3	1/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE			396	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST PATRICK, #202 S VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH APPOPULATION OF THE APPOPULATION O	OULD BE	(X5) COMPLETION DATE
G 158	to be weighed ween ursing visit notes a weight document of the second certifical 4/16/09) plan of cabe weighed weekly documentation on indicating the patient patient two times at the change in PT for the SN frequency times a week for eight week for eight week for eight week for eight week for oweek for oweek for oweek for eight week f	f care indicated the patient was kly. One out of six skilled (from 12/18/08 - 2/11/09) had red. Patient period (2/16/09 - re indicated Patient #7 was to re indicated Patient #7 was to re indicated Patient #7 was to re the skilled nursing visit notes not was weighed. Patient #7 on 2/16/09. The indicated PT would see the reweek for five weeks. Pote an MVR. The clinical amentation indicating the re of (and signed orders for) requency for Patient #7. No completed a recertification of the period 2/16/09 - 4/16/09. For Patient #7 was to be two ne week and then, one time a reks. I record contained a SN MVR is clinical record lacked physician was aware of (and the change in SN frequency for lent #7's clinical record lacked a re plan.	G	158			
		d arthritis, difficulty walking and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 11 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		297104	B. WING		03/	31/2009
	PROVIDER OR SUPPLIER E HEALTH SERVICE		396	T ADDRESS, CITY, STATE, ZIP 0 EAST PATRICK, #202 5 VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 158	performed an evaluation ordered was once a times a week for for Patient #8's clinical 11/24/08. The clinical therapy re 11/12/08. The clinical revisit notes for the The clinical record indicating the physisigned orders for) the Patient #8. On 12/7/08, Patienthospital after susta On Friday, 12/19/08 completed a resum Patient #8. The Ronursing assistant (of times a week for two The actual frequen Patient #8 after the one week, two times one time a week for Saturday, 12/27/08. The clinical record indicating the physical surface in the physical record indicating the physical surface in the same patient #8.	hysical therapist (PT) lation. The PT frequency a week for one week and three ur weeks. record contained an MVR for cal record contained one visit note for the week of cal record lacked three PT a week of 11/30/08. lacked documentation cian was made aware of (and the change in PT frequency for t #8 was admitted to the ining a fall. B, the registered nurse (RN) option of care (ROC) visit for DC frequency for the certified CNA) was ordered for two weeks. cy of CNA visits made for e ROC was once a week for es a week for one week and one week, beginning on	G 158			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 12 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		297104	B. WII	4G _	····	03/3	1/2009
NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICE				3	REET ADDRESS, CITY, STATE, ZIP CODE 1960 EAST PATRICK, #202 LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 158	The start of care for Diagnoses included insulin-dependent of artery disease. Patient #11's clinical SN one time a week for two weeks for 6 weeks. Patient #11's clinical dated 3/6/09. The documented evider aware of (and signed SN frequency for Provided Provided Average of (and signed SN frequency for Provided Average of (and signed SN frequency for Provided Average of (and signed CNA frequency for Provided Average of CNA f	r Patient #11 was 2/21/09. d a sacral pressure ulcer, diabetes mellitus and coronary al record contained orders for k for one week, two times a s and then, one time a week al record contained a SN MVR, clinical record lacked noe the physician was made ed orders for) the change in ratient #11. al record contained orders for reek for eight weeks, beginning al. al record contained a CNA The clinical record lacked noe the physician was made ed orders for) the change in Patient #11.	G	158			
	Patient #15						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 13 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

OFILE	A LO LO LA MILLO DI CALLE	d Medicinio Certifice			
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPE A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		297104	8 WNG		03/31/2009
	ROVIDER OR SUPPLIER HEALTH SERVICE		272	REET ADDRESS. CITY, STATE, ZIP C 1 E. Russell Road Vegas, NV 89120	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTION
G 158	Continued From pa	ige 13	G 158		
	Diagnoses included obstructive pulmon insulin dependent of PT orders for Patie	nt #15 were one time a week			
	for one week and to weeks.	nen, two times a week for five			
	MVRs. The clinical indicating the physical	and 3/14/09, the PT wrote I record lacked documentation ician was made aware of (and the change in PT frequency.			
G 159	484.18(a) PLAN O	s week began on Sunday. F CARE eveloped in consultation with	G 159	diagnoses will be included agency will request all pert sources (i.e.: hospitals, MI	inent information from referral
	the agency staff co including mental st equipment requires	vers all pertinent diagnoses. atus, types of services and f, frequency of visits.			red to the Agency. Patient 15 ed from home care. All
	limitations, activitie	abilitation potential, functional vities permitted, nutritional medications and treatments, any		 The Agency will confirm all etc. referrals and obtain all including medical history/d etc. for all patients receiving 	pertinent information octor discharge instructions,
		ely discharge or referral, and		C. Intake staff will be instructored diagnosis, and other signiful referring M.D. and referral office manager will track a request medical history, diagnostic medical history, diagnostic medical states.	icant information from the sources for all patients. The Il hospitalized patients and
	Based on interview facility failed to ens	is not met as evidenced by: and clinical record review, the sure the plan of care included uses for 1 patient (#15).		instructions from the hospi patients receiving agency will also obtain a perlinent diagnosis from the patient care, and document in the pertinent diagnoses will be	tal for all hospital discharged care. The start of care nurse history and significant or caregiver at the start of start of care packet. All added to the POC during e
	Findings include:			An in-service has been he all staff (visiting and office)	
	Patient #15			action (See Agenda - Attac service will be repeated du 2009 with mandatory atten	ring the week of May 11-15,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 14 of 33



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE	& MEDICAID SERVICES				OISIG 140. 0330-0331		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A BUILO	LTIPLE CONS	TRUCTION	X3) DATE SURVEY COMPLETED		
		297104	B WING			03/31/2009		
NAME OF P	ROVIDER OR SUPPLIER				DRESS. CITY, STATE, ZIP CODE			
AT HOME	HEALTH SERVICE		2721 E. Russell Road Las Vegas, NV 89120					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUSS-REFERENCED TO THE APPROPRIEST OF THE APPROPRI	ULD BÉ COMPLETION		
G 159	Diagnoses included obstructive pulmon insulin-dependent of Patient #15 was on The plan of care dias one of the diagn On 3/27/09 at 10:40 indicated the agent documentation from hospitals (history a summaries, etc.) w	r Patient #15 was 2/24/09. d multiple sclerosis, chronic ary disease, hypertension and diabetes mellitus. an anti-seizure medication. d not include seizure disorder	G 15	69 D.	The Clinical Director will continue ensure that all pertinent diagnosi any medications that are prescrib provided to all disciplines perforn All pertinent diagnoses will be ad as indicated. The Clinical Direction will be respirith assistance from the CA staff (visiting and office) have of Care and importance of all sig documented as obtained by the vithe Clinical Director/QA staff will committee in regards to the Ager corrective action. Date of Completion: June 19, 20	s are included especially for ped. The plan of care will be ning services to the patients. Ided with a physician's order consible for the Plan of Care f, intake, and SOC nurse, been instructed on the Plan inficant/pertinent diagnoses visiting nurse. In addition, report monthly to the Plancy's compliance with this		
G 160	that cannot be comvisit, the physician additions or modifications or modifications or modifications. This STANDARD Based on interview agency failed to enconsulted to modify of 15 patients (#1.) Findings include: Patient #1 The start of care for Diagnoses include the present and no mellitus.	is a patient under a plan of care apleted until after an evaluation is consulted to approve cation to the original plan. is not met as evidenced by: and clinical review, the sure the physician was a the original plan of care for 4 3, 7, 10). In Patient #1 was 6/20/08. In the distribution of the original plan of care for 4 3, 7, 10).	G 16	60 A. B.	The intake staff will assign the Therapists immediately to allo evaluation within 72 hours of the Physician and other discipline delay in therapy evaluations a be documented in the clinical will be completed as indicated. Therapists will be instructed to within 72 hours of MD referral physician and disciplines to no staff will be instructed to assignimediately following therapy Clinical Director of any problet. The Agency will initiate a coor to ensure therapy evaluations manner (within (72 hours of restaff and Clinical Director will for therapy. Start of Care numphysician and notify the intake required. Intake will then assitimely manner and monitor the by the Therapists. The Agency mandatory in-service on May Plan of Correction. This same repeated during the week of M this Plan of Correction, and of staff. Attendance will be docu Attachment A).	w the therapist to do an he Start of Care. The se will be notified of any not this communication will record. An interim order labeled of any not this communication will record. An interim order labeled of any delay. Intake of the property of any delay. Intake in therapy cases referrals and notify the more concerns. In the property of the property		
	Ine plan of care in	cluded a physical therapy (PT)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 3VPH11

Facility ID INVS3688HHA

If continuation sheet Page 15 of 33



DEPARTMENT OF HEALTH AND HU	I SERVICES
CENTERS FOR MEDICARE & MEDICA	SERVICES

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	:	297104	B. WI	IG		03/3	31/2009
	AT HOME HEALTH SERVICE			396	ET ADDRESS, CITY, STATE, ZIP CODE 60 EAST PATRICK, #202 S VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 160	evaluation. The PT days after the start lacked documentat of the delay of the IP. According to the According to the According to the According receipt of referral)." On 3/27/09 in the mindicated their policitherapy (OT) "up to care to perform an Patient #3 The start of care for Diagnoses included (Parkinson's disease) The start of care or PT and OT evaluated According to the climater. OT saw the plays after the start. The clinical record documentation indinotified of the delay evaluations. Patient #7	r evaluation was performed 15 of care. The clinical record ion the physician was notified PT evaluation. gency's Policy Number 3.1, ctive 6/22/06, "Therapies and MSW: Within 72 hours finitial or subsequent norning, the director of nursing cy allowed PT and occupational at 48 hours" after the start of evaluation. The Patient #3 was 3/20/09. It paralysis agitans see) and difficulty walking. The ders for Patient #3 included ions. Inical record, PT saw Patient in four days after the start of patient for an evaluation five of care. For Patient #3 lacked icating the physician was	G	160			
	Diagnoses included	d hypertension, congestive					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 16 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN		ISTRUCTION	(X3) DATE SURVEY COMPLETED
		297104	B WING_			03/31/2009
	NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICE		27	21 E. Ru:	DDRESS. CITY, STATE, ZIP COI ssell Road NV 89120	DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR EACH CORRECTIVE ACTION SI OSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
	on 12/18/08, a PT Patient #7. The climissed visit reports documentation indinotified of the delay On 2/16/09, Patient #10 The start of care for Diagnoses included hypothyroidism, mula fall. The plan of eservices and a PT of Services and a PT of Services of record documentation indinotified of PT's inaligation. 484.18(c) CONFOR ORDERS Verbal orders are produced with the date nurse or qualified the	evaluation was ordered for nical record contained four in the clinical record lacked cating the physician was in treatment. #7 was evaluated by PT. #7 Patient #10 was 3/13/09 is generalized pain, iscle weakness and history of care called for skilled nursing evaluation. ote written by the intake #70, indicated PT was unable as the patient was not at the The clinical record lacked cating the physician was billity to see and evaluate the RMANCE WITH PHYSICIAN out in writing and signed and of receipt by the registered herapist (as defined in section er) responsible for furnishing or	G 160	D. E. A. B.	and other disciplines when worder will be obtained for the Care. The Clinical Director with the QA/Intake staff will monitor of Therapy evaluations per Abe required to notify the Phyevaluation or missed visits a change in schedule. In additionant and QA staff will report monitoregards to the Agency's contaction. Date of complete: June 19, Physician signatures and care and interim orders with days per agency policy. Ehave already been dischafuture patients will be affection. All plans of care and interphysicians for signatures office manager to ensure and dated within 30 days, will monitor and track the	al evaluations are not visits are completed per orapists will notify Physicians visits are delayed and an exchange in the Plan of the compliance of the timeliness agency policy. Therapist will sician of any delay in initial and obtain an order for a tition, the Clinical Director (thy to the PI committee in appliance with this corrective). 2009 dates on all plans of till be obtained within 30 and the patients 5 and 8 arged. All current and cotted by this corrective will be tracked by the that these are signed. The Clinical Director compliance of the
		STANDARD is not met as evidenced by; d on record review, the facility failed to			return of signatures and d Care and interim orders o	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 3VPH11

Facility ID INVS3688HHA

If continuation sheet Page 17 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE	CONS	TRUCTION	(X3) DATE SURVEY COMPLETED
		297104		MNG			47/74/2007
	SOLADER OR SUSPLIES	287 104	-				03/31/2009
	AT HOME HEALTH SERVICE			2721 1	E. Russi	RESS. CITY, STATE, ZIP CODE ell Road V 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREF TAG		(E	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOT SS-REFERENCED TO THE APPR DEFICIENCY)	JED BE COMPLETION
G 166	the date of receipt I qualified therapist in supervising the ord patients (#5, 8). Findings include: Patient #5 The start of care for Diagnoses included hypertension, difficult incontinence. Patient #5's clinical care for the certificate 2/10/09. The area and date was blank Patient #5's clinical care for the period physician's order for the period physician	ry were signed and dated with by the registered nurse or esponsible for furnishing or ered services for 2 of 15 r Patient #5 was 12/13/08. It congestive heart failure, alty walking and bladder record contained a plan of ation period of 12/13/08 - for the physician's signature for the physician's signature or record contained a plan of 2/11/09 - 4/11/09 and a rewound care, both written on 1/09, both orders lacked the	G	166	D.	The Agency will continue to timeliness of retuned Physici dates on all plans of care and within 30 days per Agency per marketers will be instructed to Physicians to obtain the sign within the 30 day time frame An in-service for office staff a held May 8, 2008 (See Agenda Agency plans to repeat this siduring the week of May 11-15 mandatory attendance docur. The Clinical Director will prep to monitor compliance with the signed and dated plans of calorders. Agency office staff, marketern Director are responsible to encare and visiting interim orded dated within the 30 days time policy. The Clinical Director Agencies compliance with the tracking/monitoring on a qual addition, the Clinical Director report monthly to the PI comit the Agency's compliance with action.	an signatures and dinterim orders olicy. Agency o follow-up with ed and dated orders per Agency policy. and marketers was a - Atlachment A). The same in-service 5, 2009 with mented. The agency policy for a same in-service of a day policy for a re and interim and the Clinical ansure that plans of a re signed and a frame per Agency will monitor the sis standard through and QA staff will mittee in regards to
		r Patient #8 was 11/12/08. If arthritis, difficulty walking and		40 c saladado e - 2 c c c c c c c c c c c c c c c c c c	F.	Date of completion: June 19	, 2009.
G 169	a recertification ass the second page of 1) frequency of visit were blank. The ar- signature and date	ysical therapist (PT) performed bessment of Patient #8. On the assessment, the areas for its and 2) duration of treatment leas for the physician's were blank as of 3/31/09. URSING SERVICES	G	169	A.	LPNs and home health aids (C	NA's) will immediately

FORM CNS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

FacAty ID: NV\$3668HHA

If continuation sheet Page 18 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO: 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		KULTIPLE ILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297104	B VAN	46		03/31/2009	9
NAME OF P	PROVIDER OR SUPPLIER				ET ADDRESS. CITY, STATE, ZIP CODE		
AT HOM	E HEALTH SERVICE				E Russell Road egas, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMP	KB) LETION ATE
G 169		skilled nursing services by or on of a registered nurse.	G 1	169	be supervised every fourte needed. This will be evide documentation on the sup the clinical notes. Patients 1,5,13,14 and 15	enced by supervisory ervisory portion of have all been	
	Based on record re- ensure the registere	s not met as evidenced by view, the agency failed to ed nurse made a visit to the every two weeks for 5 of 15 14, 15).		I	discharged. All current an be affected by this correcti B. The Agency will ensure co supervision of LPNs and I monitoring of documentati supervision in the clinical r	ive action. Impliance for IHAs through QA on of this	
	Findings include:				C. The Agency has schedule		
	Diagnoses included heart failure and no mellitus. The registered nurs start of care visit on	r Patient #1 was 6/20/08. If hypertension, congestive in-insulin dependent diabetes in (RN) saw Patient #1 for the in 6/20/08. During the next ensed practical nurse (LPN)			service for all disciplines to LPN/HHA supervision. RN instructed on LPN/HHA su documentation of this superstaff have been instructed documentation of LPN/HHA Agency has scheduled an 2009, (See Agenda - Attacturing the week of May 11 attendance by all discipline	o review policies on all have been apervisory visits and ervisory visit. QA to monitor A supervision. The in-service on May 8, when the A and all have a documented.	
	saw the patient for t Patient #1's clinical	record lacked documented servisory visit was completed			D. Monitoring of LPN/HHA superformed by the QA staff, monitor the supervisory do report any problems/issue Director for immediate res	. The QA staff will ocumentation and s to the Clinical olution.	
	Diagnoses included hypertension, difficu incontinence.	r Patient #5 was 12/13/08. I congestive heart failure, Ilty walking and bladder		E	E. The Clinical Director will b LPN/HHA supervision with visiting RN nurses. The Q responsible to monitor the documentation in the clinic report any non-compliance Clinical Director for resolut Clinical Director and QA si monthly to the PI committee.	a assistance of A staff will be supervisory cal records, and a immediately to the tion. In addition, the taff will report see in regards to the	
	on 12/13/08, During	g the next four weeks, the It seven consecutive times.			Agency's compliance with action.	this corrective	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID, 3VPH11

Facility ID: NVSS688HHA

F. Date of completion: June 19, 2009.

If continuation sheet Page 19 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WNG			
		297104			03/31/2009	
	AT HOME HEALTH SERVICE			REET ADDRESS, CITY, STATE, ZIP CODE 1960 EAST PATRICK, #202 LAS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 169	Continued From pa	ge 19	G 169			
	l .	record lacked documented pervisory visit was completed LPN.				
	Patient #13					
	Diagnoses included	r Patient #13 was 1/28/09. d abscess to the buttock area, nyalgia and difficulty walking.				
	on 1/28/09. During	at #13 for the start of care visit the next six weeks, the LPN ven consecutive times.				:
		al record lacked documented pervisory visit was completed LPN.				
	Patient #14	I P				
	The start of care fo Diagnoses included hypertension and c					
	on 2/25/09. During	nt #14 for the start of care visit the next three weeks, the nt four consecutive times.				
		al record lacked documented pervisory visit was completed LPN.				
	Patient #15					
	Diagnoses included	r Patient #15 was 2/24/09. d multiple sclerosis, chronic ary disease, hypertension and diabetes mellitus.			,	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 20 of 33

RECEIVED MAY 1 1 2009

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES				011101101	0330-0331		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		297104	B WING			03/3	1/2009		
	ROVIDER OR SUPPLIER HEALTH SERVICE		STREET ADDRESS. CITY, STATE, ZIP CODE 2721 E. Russell Road Las Vegas, NV 89120						
(X4) 10 PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE PROPERTY)	ULD BE	(X5) COVPLETION DATE		
G 169	Continued From pa	ge 20	G 169				*		
	on 2/24/09. During LPN saw the patier Patient #15's clinical evidence that a sup	t #15 for the start of care visit the next three weeks, the it five consecutive times al record lacked documented pervisory visit was completed LPN.							
G 172	by the RN with the LPN. 484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.		G 172		A registered nurse (RN) will re-evaluate the patient or regular basis (every 14 days) or when a change occupatient's condition. When a LPN is scheduled to ser patient, a RN will evaluate the patient every 14 days often as necessary per changes in the patients cond. Visiting RNs will be re-evaluate the patient every 14 when the patient's condition changes. Visiting LPNs Therapists, and all other disciplines will immediately changes in the patient's condition to the Clinical Dire				
	Based on clinical reto ensure the regist	nt #1		C.	and the patient will be immediately re-evaluated, and coordination with the Physician completed as indicated				
	Diagnoses included heart failure and no mellitus. The licensed practiful and the clinical record re-evaluated the paweeks. On 7/28/08 and 8/4 Patient #1 had ede The clinical record indicating the RN w	cal nurse (LPN) saw Patient eight consecutive weeks. lacked documentation the RN attent's needs during the eight welling) in the lower legs lacked documentation was notified. The clinical recordion indicating the RN		D.	·	dition or needs r. The Clinical uated on a reg QA staff will in the patients 's will be assig- as needed pe esible for monit ange in plan or the Healt al Director and ittee in regards	Director will ular basis monitor condition or ned to re- r changes in oring re- f Care with h Aids and d QA staff		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID, 3VPH11

Facaty ID INVS3688HHA

If continuation sheet Page 21 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	:	297104	B. WI	NG _	**************************************	03/3	1/2009
	NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICE			39	EET ADDRESS, CITY, STATE, ZIP CODE 960 EAST PATRICK, #202 AS VEGAS, NV 89120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 172	Diagnoses included hypertension, difficult incontinence. The RN saw Patien evaluation. The LP consecutive times. In the sixth full wee period, the patient of the sacral/coccygeal acked documentation re-evaluated the patient #5 eight this time (six weeks blisters on the upperhad bloody drainaged documentation indice Patient #5's needs the start of care for Diagnoses included chronic pain, fibrom After the RN complement #13, the LP over six weeks.	r Patient #5 was 12/13/08. I congestive heart failure, alty walking and bladder It #5 for the start of care N saw the patient 10 It would be a pressure ulcer to all area. The clinical record ion indicating the RN itient's needs during this time. I we determine the electron of the el	G	172			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 22 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

OFILE	10 1 OIL HIEDIONIL	. U IIILDIONIO OLIVIOLO				OTHE TTO: 0400 400 T
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MU A BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		297104	8 VANO	·		03/31/2009
NAME OF P	ROMDER OR SUPPLIER			etpi	EET ADDRESS. CITY, STATE, ZIP CODE	
AT HOM	E HEALTH SERVICE			2721	E. Russell Road /egas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	:	PROVIDERS PLAN OF CURREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
G 172	Continued From pa	ge 22	G 1	72 F.	Date of completion: June 19, 20	09.
	indicating the RN re needs during this ti	e-evaluated Patient #13's				
G 173	484.30(a) DUTIES NURSE The registered nurs	OF THE REGISTERED se initiates the plan of care and	G 1	73 _{A.}	and initiate revisions to this plan necessary. The physician will be orders (i.e.: frequency of labs, e	of care as deemed e contacted for specific etc.). Documentation of
	necessary revision	S .			all orders will be specific and de- future patients will be affected by Patients 2 and 5 have already by	y the corrective action.
	Based on clinical re	is not met as evidenced by ecord review, the registered of initiate revisions to the plan of elents (#2, 5).		B.	The Clinical Director will monitor physician orders and plans of ca physician orders are complete, s	re to ensure that all
	Findings include:			C.	The Agency has scheduled a management Agency has scheduled a management Agency and accurate complete, specific and accurate	lisciplines (See Agenda - cluded instruction on orders. The Agency
	Diagnoses included	r Patient #2 was 11/11/08. d long term current use of ep vein thrombosis (DVT) and			plans to hold the same in-service 11-15, 2009 with mandatory atted documented. This in-service will the Clinical Director.	indance by all disciplines
	The start of care or receive Lovenox 10 twice a day for thre	ders called for Patient #2 to 00 milligrams subcutaneously the days and Coumadin 7.5		D.	All initial/concurrent physician or have been reviewed by the Clini corrected as needed. This corre and for all current and future pat POCs/revisions are initiated as i	cal Director and active action will continue ients to ensure all
	to have "PT/INR (la	rders indicated Patient #2 was ab draw) per MD order."		E.	The Clinical Director is responsi physician orders and plans of ca will assist in ensuring that all phy of care are complete, specific ar any problems/issues to the Clini	ire. QA staff and RNs ysician orders and plans ad accurate, and report cal Director. In addition,
	indicating the skille	lacked documented evidence d nurse (SN) called the r specific orders for a aws.		_	the Clinical Director and QA staf the PI committee in regards to the with this corrective action.	ne Agency's compliance
	Note: Patient #2 w facility six days after	ras admitted to an acute care er start of care with an INR of		F.	Date of completion: June 19, 20	ius

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 3VPH11

Facility ID, NVS3658HHA

If continuation sheet Page 23 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		297104	B. WING _		03/3	1/2009
NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH SERVICE		3	REET ADDRESS, CITY, STATE, ZIP CODE 960 EAST PATRICK, #202 AS VEGAS, NV 89120			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 173	Diagnoses included hypertension, difficult incontinence. The start of care ord "Change cath (indomonth inflated with balloon" The start of care ord specific size of the disolution to instill into 12/5/08 - 2/2/09 and "Change cath (indomonth inflated with balloon" The receipting size of the disolution to instill into 20 specific size of the disolution to instill into 20 specific size of the disolution to instill into 20 solution to i	Patient #5 was 12/13/08. congestive heart failure, alty walking and bladder ders for Patient #5 read, welling urinary catheter) every 30 cc (cubic centimeters) ders for Patient #5 lacked the catheter and amount of 50 the 30 cc balloon. Inders for the two periods of 12/3/09 - 4/3/09 both read, welling urinary catheter) every 30 cc (cubic centimeters) entification orders lacked the catheter and amount of 50 the 30 cc balloon. Inders for the two periods of 12/3/09 - 4/3/09 both read, welling urinary catheter) every 30 cc (cubic centimeters) entification orders lacked the catheter and amount of 50 the 30 cc balloon. Inders for the two periods of 12/3/09 - 4/3/09 both read, welling urinary catheter) every 30 cc (cubic centimeters) entification orders lacked the catheter and amount of 50 the 30 cc balloon. Independent #16 with 30 cc G 173				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 24 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		297104	B. WING		03/3	31/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE		390	ET ADDRESS, CITY, STATE, ZIP COI 60 EAST PATRICK, #202 S VEGAS, NV 89120	*****	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 173	indicating the RN h obtain specific order balloon and amount balloon. Patient #5's clinical dated 3/5/09 which replaced with #18 F balloon" Patient #5's clinical indicating the RN c	record lacked documentation ad contacted the physician to ers for the size of the catheter, the offluid to be instilled into the record contained a SN note read, "catheter removed and rench with 30 milliliters record lacked documentation ontacted the physician to my revisions to Patient #5's	G 173			
G 176	plan of care. 484.30(a) DUTIES NURSE The registered nurs progress notes, coo physician and othe patient's condition a This STANDARD is Based on clinical res	of the registered and ordinates services, informs the repersonnel of changes in the and needs. s not met as evidenced by: ecord review, the facility failed	G 176			
	physician of change of 15 patients (#1, : Findings include: Patient #1 The start of care for Diagnoses included	tered nurse informed the es in condition and needs for 4 2, 5, 6). The Patient #1 was 6/20/08.	The Post of the Po			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3688HHA

If continuation sheet Page 25 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES			OIND MO. 0330-0331
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		297104	B. WING _		03/31/2009
NAME OF P	ROVIDER OR SUPPLIER		6.	TREET ADDRESS. CITY, STATE, ZI	P CODE
AT HOME	HEALTH SERVICE		27	721 E. Russell Road as Vegas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF IEACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION DATE
G 176	practical nurse (LP indicated Patient # (swelling) in both lot Patient #1's clinical the LPN notified the changes. Patient #2 The start of care for Diagnoses included anticoagulants, deen not specified and created disease (COPD). The start of care or receive Lovenox 10 twice a day for three milligrams by mout the start of care or to have "PT/INR (later the clinical record indicating the SN created specific orders to describe the start of care or to have "PT/INR" (later the clinical record indicating the SN created specific orders to describe the start of care or to have "PT/INR" (later the clinical record indicating the SN created specific orders to describe the specific orders to describe	notes written by the licensed N), dated 7/28/08 and 8/4/08, I was experiencing edema wer extremities. record lacked documentation a registered nurse of the registered nurse	G 176	A. The LPN will immedin the patient's cond (RN) and/or the Clir RN/Clinical Director inform the physician patient's condition of necessary changes the physician and descriptions involved addition, all RNs will and accurate orders start of care and as changes in the Plant All current and future this corrective action have all been discheservices. B. All clinical notes will concurrently monitod that physicians have changes in the patie orders will be monit Clinical Director for and follow-through. C. The Agency has set service on May 8, 2 Attachment A), for a on the process of modification, documentation and changes in the plant plant to hold an addition, service during the with attendance by This in-service will to the process of the with attendance by This in-service will the service will the process of the plant plant to hold an addition and changes in the plant plant to hold an addition and changes in the plant plant to hold an addition and the process of the plant plant to hold an addition and changes in the plant plant to hold an addition and the process of the plant plant to hold an addition and the pl	diately report any changes dition to a registered nurse sical Director. The will then immediately of the changes in the or needs and coordinate all in the Plan of Care with isciplines. Changes in the communicated to all in the patient episode. In I obtain complete, specific of from the physician at the deemed necessary per of Care. The patients will benefit from the patients 1,2,5 and 6 arged from home health The immediately are by QA staff to ensure the been notified for all the completeness, accuracy, the deduct a mandatory incomplete in the patient disciplines of the patient of these of care. The Agency ditional mandatory incovered in the patient of these of care. The Agency ditional mandatory incovered of May 11-15, 2009 all disciplines documented.
	Diagnoses include	r Patient #5 was 12/13/08. d congestive heart failure in, difficulty walking and		Clinical Director.	

FORM CMS-2567(02-99) Previous Versions Obsolete Evi

Event ID 3VPH11

Facety ID NVS3685HHA

If continuation sheet Page | 26 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CEITTE	VO LOU INFORMATION	CHILDICAID SERVICES			ONID 110. 0330-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROMOER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTH A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		297104	B. WING		03/31/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE		272	REET ADDRESS. CITY, STATE, ZIP CODI 1 E. Russell Road Vegas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
G 176	an open wound on indication the RN (athe change in cond wound dimensions 2/15/09, 2/12/092/1 documentation lact physician) was not On 3/4/09, the LPN sacrum was heated patient had a wounteft upper back with nurse visit note fact the RN (or physicial wound. On 3/11/09, the LPN aright upper back mention of drainage documented the pauper back measure with bloody drainage. Patient #6 The start of care for Diagnoses included retention, blindness diabetes mellitus. After the registered #6, the LPN saw the patient refused to a	N documented Patient #5 had the sacrum. There was no or physician) was notified of lition. The LPN documented (length and width) on 1/29/09, 18/09, 2/27/09. The ked indication the RN (or lifed. I documented patient #5's d. The LPN documented the indication in the loody drainage. The skilled ked documentation indicating in) was notified of the new IN documented Patient #5 had wound (no measurements, no e). On 3/17/09, the LPN intent had a wound on the right ling "1.5 in size, 0.5 in depth	G 176	 D. The Clinical Director and accomplish monitoring thin The QA staff will review at concurrent basis. The Climonitor/evaluate all physical as receiving communication reporting changes on the needs and coordinate/docchanges per Agency procepreviously. E. The Clinical Director will be monitoring compliance of action. The QA staff and assist and report to the Clinical monthly to the Plent Date of completion: July 1 F. Date of completion: July 1 	s corrective action. Il clinical notes on a nical Director will cian orders as well on from disciplines patient's condition or tument these tess mentioned The responsible for this corrective visiting staff will inical Director. tective action will be committee.

record lacked documentation indicating the nurse

PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES					OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MI A. BUIL		CONS	TRUCTION	(X3) DATE SURVEY COMPLETED
		297104	8 WN	G			03/31/2009
	ROVIDER OR SUPPLIER			2721 E.	. Russi gas, N	RESS. CITY, STATE, ZIP CODE eil Road V 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(E	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO ISS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
G 176	allow blood glucose	an of the patient's refusals to echecks.	G 1	176			
	and 10/15/08, the L nursing (DON) that the LPN check bloc record lacked docu notified the physicia 484.30(a) DUTIES NURSE	the LPN notified the director of the LPN notified the director of that Patient #6 was refusing to let blood glucose levels. The clinical documentation indicating the DON sysician of the patient's refusals.		177	Α.	The registered nurses (RNs) (LPNs) nurses will immediate patients and caregivers rega	ely instruct/counsel rding the plan of care
	family in meeting n This STANDARD Based on clinical n nurse (RN) failed to	se counsels the patient and ursing and related needs. is not met as evidenced by: ecord review, the registered o counsel (instruct) the provide wound care for 1 of 15				and related needs including disease process, safety, infe maintenance, wound care, F management etc. The goal and caregivers to achieve inincluding return demonstration ecessary. Patient number discharged from home healt current and future patients we corrective action.	ction control, health oley care, pain is to assist the patient dependent in care ons of all treatments as 5 has already been h services, however all itle be affected by this
	Findings include:				8.	The QA staff will monitor all evidence of documentation of and return demonstrations of needs.	of teaching, instruction,
	Diagnoses include hypertension, difficult incontinence. The clinical record order dated 1/22/0 wound with norma	or Patient #5 was 12/13/08. d congestive heart failure, sulty walking and urinary for Patient #5 contained an 8 which read, "Cleanse coccyx I saline, pat dry, apply th gauze, secure with tape			C.	The Agency has scheduled on May 8, 2009 for all appro Agenda – Attachment A). The teaching/counseling of patie in-service was presented by The Agency plans to hold the the week of May 11-15, 200 attendance by all disciplines. The QA staff will monitor all documentation of teaching/in	priate disciplines (See his in-service covered umentation of ints and caregivers. This the Clinical Director. e same in-service during 9 with mandatory documented. clinical notes for instruction and return
	every day."	lacked documentation				demonstrations of the patien will report to the Clinical Dire problems/issues noted for in	ts and caregivers and ector any

FORM CNS-2587(02-99) Previous Versions Obsolete

indicating the RN taught Patient #5 and/or the

Event ID: 3VPH11

Facility ID NVS3686HHA

If continuation sheet Page 28 of 33



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED. 04/27/2009 FORM APPROVED OMB NO 0938-0391

CENTER	(2 FOR MEDICARE	9 MEDICAID SERVICES				OIND INC	0330-0331
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN		ONSTRUCTION	(X3) DATE SI COMPLE	
		297104	B. WING			03/3	1/2009
NAME OF P	ROMDER OR SUPPLIER		: ,	TREE	T ADDRESS. CITY, STATE, ZIP COD)F	
AT HOME	E HEALTH SERVICE		2	721 E	. Russell Road gas, NV 89120	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
G 177	indicating the licens Patient #5 and/or the the wound. The clinical record indicating Patient #	-	G 177	E.	The Clinical Director is responsib teaching/instructing the patient arbeing performed for all patients/c Director will be assisted by the Oclinical notes for evidence of teaching/instructing/counseling/re all patients/caregivers. In additionand QA staff will report monthly to regards to the Agency's compliantation. Date of correction: June 19, 2009	nd/or caregivers aregivers. The A staff in monito eturn demonstra in, the Clinical Doot the PI commit noe with this cor	is Clinical oring all itions for director tee in
G 178	NURSE The registered num	OF THE REGISTERED se participates in in-service ervises and teaches other	G 178	A.	Agency in-services are provided for attendance is documented on a reg monthly). RNs/Clinical Director will LPNs and CNA/HHAs on patient ca needed per changes in the plan of the disciplines. Patient number 1 hid discharged from home health servicand future patients will be affected by	jular basis (at lea I supervise and in tre every 14 days care, and as need as already been ces, however all o	st estruct and as ded by current
	Based on clinical re to ensure the regis	is not met as evidenced by: ecord review, the agency failed tered nurse (RN) performed of the licensed practical nurse patients (#1).		B. C.	The Agency will ensure compliance HHAs and CNA through QA monito this supervision in the clinical record. The Agency has scheduled a mand 8, 2009 (See Agenda – Attachment review policies on LPN/CNA/HHAs has been instructed to monitor doct LPN/CNA/HHA supervision. All RN on LPN/CNA/HHA supervision. All RN on LPN/CNA/HHA supervisory visits this supervision. The Clinical Direct service. The Agency plans to hold tweek of May 11-15, 2009 with attendocumented.	oring of document ds. (atory in-service of A) for all discipling supervision. The numeritation of all the beautiful documentation presented the this same in-services.	ation of on May nes to QA staff ructed tition of is in- rice the
	The start of care for Diagnoses included heart failure and no mellitus. The plan of care in one time a week to for two weeks and weeks. The RN person of the care in the care	or Patient #1 was 6/20/08. If hypertension, congestive on-insulin dependent diabetes dicated the SN frequency was or one week, two times a week then, one time a week for six enformed the first (start of care) of the natient for the duration of		D.	Monitoring the corrective action will staff concurrent review of clinical no documentation of LPN/CNA/HHA si as needed. QA staff will report to the intervention as often as necessary resolution of any problems/issues with the Clinical Director is responsible compliance with this corrective action the Clinical Director by monitoring director for evidence of LPN/CNA/HH addition, the Clinical Director and Q to the PI committee in regards to the with this corrective action.	otes for evidence upervision and in the Clinical Director for immediate with non-compliar for monitoring on. QA staff will of documentation. In A supervision. In QA staff will report	of struction or for noce. assist clinical clini

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D. 3VPH1)

Facaty ID INVS3658HHA

If continuation sheet Page 29 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO 0938-0391

	CO I OIL MEDICALLE	A THE DIOTHE CENTROLE			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		297104	B WING	*****	03/31/2009
NAME OF P	ROVIDER OR SUPPLIER		2721 [ET ADDRESS. CITY, STATE, ZIP (E. Russell Road	CODE
AT HOME	HEALTH SERVICE		Las V	egas, NV 89120	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE
G 178	Continued From pa	ge 29	G 178	F. Date of completion: June	19. 2009
	the certification per	iod.			
	had performed a su	lacked documentation the RN pervisory visit for the LPN.			
G 185	484,32 THERAPY	SERVICES	G 185		I immediately be provided an orders and plans of care.
	or under arrangement therapist or by a qu	es offered by the HHA directly ent are given by a qualified alified therapy assistant under a qualified therapist and in e plan of care.		Therapists will evaluate hours of the Physicial will be notified of any schedule and a new care obtained from the coordinated/docume Patients 1 and 15 has from service. All currents	ate the patient within 72 an's referral. The Physician order for the revised plan of the Physician and anted with disciplines. The patients will
		s not met as evidenced by		be affected by this co	orrective action.
	review, the agency qualified therapist v	ecord review and document failed to ensure services of a vere delivered in accordance e for 3 of 15 patients (#1, 3,		staff will immediately evaluation. Therapis Physician and Clinica any delay in service completed within 72	sts are required to notify the al Director immediately for (any evaluation that is not
	Patient #1				t to the constant of the
	Diagnoses included heart failure and no mellitus The referral for Pat The referral include physical therapy (Poccurred 15 days a patient. Patient #1's clinical indicating the physical included in the physical indicating	r Patient #1 was 6/20/08. If hypertension, congestive on-insulin dependent diabetes dient #1 was dated 6/19/08. If skilled nursing (SN) and (T). The PT evaluation after the nurse admitted the died therepist spoke with the gather delay in treatment.		service on May 8, 20 disciplines (See Age in-service addressed hours) of Therapy ev been instructed to no of new Therapy evaluation in the so evaluation and docur communication with disciplines, as well a sa indicated. The Agmandatory in-service	eduled a mandatory in- 309 for all appropriate nda – Attachment A). This if timely scheduling (within 72 valuations. Intake staff have botify Therapists immediately uations. Therapists have botify Physicians of any delay scheduling of their initial ment and coordinate this the Physician and involved s complete a physician order gency will repeat this d during the week of May 11- ance by all disciplines

Event ID 3VPH11

Facaby ID NVS3686HHA

If continuation sheet Page 30 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

CENTER	13 FOR MEDICARE	A MEDICAID SERVICES	_				
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		297104	e w	4G		03/31/2009	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS. CITY, STAT, ZIP CODE	-	
AT HOM	E HEALTH SERVICE			2721 E.	Russell Road ass. NV 89120		
(X4) IO PREFIX TAG	EACH DEFICIENCY	STEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE COMPLETION	
G 185	Continued From pa	ge 30	G	185 D.	Monitoring of this corrective a	ction will be	
	Patient #3				accomplished by the intake s The QA staff will review the c	taff and QA staff.	
	Diagnoses included	start of care for Patient #3 was 3/20/09 noses included paralysis agitans kinson's disease) and difficulty walking.			evaluations by the Therapists and intervention as necessar staff will monitor the timely so Therapy evaluations and repo	ofor compliance y. The intake sheduling of ort any problems	
		ient #3 was dated 3/17/09 ed SN, PT and OT. The PT			or issues with delays immediately to the Clinical Director for appropriate intervention.		
	admitted the patien	d four days after the nurse t. The OT evaluation occurred nurse admitted the patient		E.	The Clinical Director is responsible monitoring compliance with the action. The QA staff and inta	nis corrective ke staff will assist	
	Patient #15				in monitoring the scheduling, and reporting immediately to	the Clinical	
	Diagnoses included obstructive pulmon	art of care for Patient #15 was 2/24/09. ses included multiple sclerosis, chronic stive pulmonary disease, hypertension and dependent diabetes mellitus.			Director any problems or issuscheduling of Therapy evalua and QA staff and Clinical Dire on the compliance of this commonthly to the PI committee.	itions. The intake actor will report	
	The referral include	ient #15 was dated 2/23/09 ed SN and PT. The PT d four days after the nurse et.		D.	Date of completion: June 19,	2009	
	Assessments Patie Number: 3.1, effect ST, and OT) and M	gency's Policy Section: ent Initial Assessments, tive 6/26/06, "Therapies (PT, ISW; Within 72 hours f initial or subsequent					
G 188	484.32 THERAPY	therapist advises and consults with dother agency personnel		188 _{A.}	The Agency will improve the liaison between all disciplines (Therapist, N	lurses, etc.) by	
					mandating that communication occurevery 2 weeks and as needed (i.e.; patient's condition). All disciplines to communication on the clinical notes of care box and on the case conference.	change in the will document this in the coordination	
i	Based on clinical re	is not met as evidenced by: ecord review, the therapist th agency personnel regarding			(2) weeks and as deemed necessal have already been discharged from and future patients will benefit from action.	ry. Patients 8 and 15 services. All current	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 3VPH11

Facility ID NVS3688HHA

If continuation sheet Page 31 of 33



PRINTED: 04/27/2009 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONST	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	DEMINICATION NUMBER	A BUILDING				
		297104	B. WING			03/31/2009	
NAME OF P	ROMDER OR SUPPLIER				SS. CITY, STATE, ZIP CODE		
AT HOME	HEALTH SERVICE			i. Russell R Igas, NV 89			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPR DEFICIENCY)	DID BE COMPLETION	
G 188	Continued From pa	ge 31	G 188	В.	The Agency will ensure co	mpliance with this	
	2 of 15 patients (#8	, 15)		-	corrective action by monitor	oring documentation in	
man	Findings include:				on a concurrent basis and as needed.		
	Patient #8			C.	The Agency has schedule service on May 8, 2009 for	all disciplines on care	
		r Patient #8 was 11/12/08. J arthritis, difficulty walking and			coordination and documer coordination (See Agenda Agency plans to hold the s	- Attachment A). The	
	history of falls.		1		the week of May 11-15, 20 all disciplines documented	09 with attendance by	
		record contained an by (OT) revisit note, dated			be presented by the Clinic	al Director.	
	12/31/08. On the r	ote, the OT wrote " Pt		D.	Monitoring the corrective a accomplished by QA staff		
i	(patient) reported a trying to transfer or	fall from last night as she was nto commode"			Director's concurrent revie clinical notes and case con	w of the disciplines' oference notes with	
		record lacked documented			intervention initiated as ne report any problems or iss	ues immediately to the	
	evidence the OT no regarding the fall.	otified the registered nurse			Clinical Director for resolution. Compliance with this corrective action will be reported on a monthly basis to the PI committee 1.		
· -	Patient #15			E.	The Clinical Director is res		
		r Patient #15 was 2/24/09			compliance with this corre- staff will assist and report	to the Clinical Director	
		d multiple sclerosis, chronic ary disease, hypertension and			as needed, but at least we compliance. In addition, th		
	insulin dependent of				QA staff will report monthly regards to the Agency's co	y to the PI committee in	
		t #15 told the physical therapist d to be very active because			corrective action.		
	activity might bring	on a seizure. The clinical		F.	Date of completion: June	19, 2009	
	spoke with the nurs	mentation indicating the PT see regarding the patient's					
G 337	concern. 484,55(c) DRUG R	EGIMEN REVIEW	G 337	A.	The Agency requires a c assessment and drug re	gimen review to be	
	The comprehensiv	e assessment must include a			resumption of care, recei		
	review of all medic	ations the patient is currently			discharge from care. Th	e comprehensive	
		entify any potential adverse actions, including ineffective			assessment/drug regime updated per changes in t		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3VPH11

Facility ID: NVS3888HHA

If continuation sheet Page 32 of 33



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					CMR NO	0379-0731
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1. (IULTIPLE	CON	STRUCTION	(X3) DATE SI COMPLE	
		297104	B. Wi	NG			03/3	1/2009
	ROVIDER OR SUPPLIER E HEALTH SERVICE			2721	E. Rus	DDRESS. CITY, STATE, ZIP CODE ssell Road NV 89120		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREF TAC	'IX		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO IOSS-REFERENCED TO THE APPR DEFICIENCY)	AFD BE	(X5) COMPLETION DATE
G 337	drug interactions, de noncompliance with the STANDARD is Based on clinical reto ensure the compincluded a review oby 1 of 15 patients. Findings include: Patient #2 The start of care for Diagnoses included and chrondisease. The start of care of the start of	icant side effects, significant luplicate drug therapy, and in drug therapy. Is not met as evidenced by: ecord review, the agency failed by the ecord review assessment of all medications being used (#2). If Patient #2 was 11/11/08, doing term current use of ep vein thrombosis site not nic pulmonary obstructive	G	337	B. C. E.	All potential adverse effects relative regimen are included in the start as given to the patients as indica of care. Any problems (i.e. adve by the clinical staff are immediat Physician for changes in the me Plan of Care. Patient number 2 discharged from care. All currer benefit from this corrective action. The Agency will ensure compliant through QA monitoring of docum of all adverse effects, drug react treatment, significant side effects comprehensive assessment and will be accomplished by the QA: Director's initial/concurrent revier assessment of drug regimens. The Agency has scheduled a maximum and the potential defects, drug reaction, ineffective significant side effects, etc. (See A). The QA staff has been instrudocumentation and report any proclinical Director. The Clinical Dithis in-service. The Agency plar mandatory in-service during the 2009 with attendance by all discompliance with this corrective action. Monitoring this corrective action QA staff and Clinical Director remedication including initial/conceffects/drug reactions, ineffective significant side effects, etc. documented to the plan of care by the The Clinical Director is responsitionally incompliance with this corrective assist and report to the Clinical Clinical Director and QA staff will PI committee in regards to the Athis corrective action.	of care packe ated during the rise effects) as ely reported to dication regime has already be at and future part. Ince for all patitions, ineffectives, etc. on the drug regimen staff and the Cow of all compressing potential or drug treatments and atory in-series and and atory in-series and and atory in-series to hold samweek of May diplines documentation and clinical Direction. The QADirector. In addit report monthing gency's comp	t as well episode ssessed to the en and sen attients will ents entification e drug t. This dinical ehensive rvice on adverse nt, achment or the ues to the sented e 11-15, ented. plished by shensive I adverse , t d QA tor. ing A staff will dition, the by to the
					•			

